



HOW CAN WE HELP YOU TO HELP YOUR PATIENTS?

DECEMBER 8, 2011

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Cancer Resource Network



1. 800. 227. 2345
[www. cancer. org](http://www.cancer.org)

Cancer Resource Network



Umbrella name for the Society's programs and services available to assist persons affected by cancer

Goals

- Deliver timely information and support programs
- Promote informed decision making
- Enhance quality of life for survivors and caregivers



Benefits to referring patients to the American Cancer Society



Having cancer is hard. Finding help shouldn't be.
The American Cancer Society can help.



Easy to understand **information** to help you make decisions about your care.



Referral for **day-to-day** questions such as financial, insurance, transportation, and lodging.



Connection to others who have been there for **emotional support**.



Information



 **Information**

- Free detailed information packets available for all types of cancer.
- Phone help: 1-800-227-2345
- On the internet: www.cancer.org
- Tools to help with treatment





Day-to-Day Help



- Look Good Feel Better
- Wigs & Prosthesis
- Lodging and transportation assistance
- Help with financial and insurance questions
- Prescription drug assistance

Emotional Support



 **Emotional Support**

- Reach to Recovery
- Finding local support groups
- Online community for cancer patients and their families
- Cancer education classes



Direct Fax Referral Program: What Is It?

A simple new method for referring patients to the American Cancer Society for information, day-to-day help or emotional support.



Direct Fax Referral Program: What Do Patients Receive?



- Information from the American Cancer Society about their cancer diagnosis.
- A direct link to the American Cancer Society's services and resources.
- The empowering force of reliable information.



Direct Fax Referral Program: What Do Clinicians Receive?



- Peace of mind that patients receive trustworthy cancer information from the American Cancer Society.
- The satisfaction that well-informed patients understand their cancer better and are better equipped to make decisions.

How do we refer patients to these programs?



Patient Referral Form

For immediate assistance call us anytime at 1-800-227-2345.

Date: ____/____/____



Please PRINT

Patient's Name _____ Email _____

Home Address _____

City/State/Zip _____

Primary Ph # (____) _____ ☐ Hm ☐ Wk ☐ Cell Alternate Ph # (____) _____ ☐ Hm ☐ Wk ☐ Cell

Best time to call _____ AM ☐ PM OK to leave message identifying ourselves as ACS? ☐ Yes ☐ No

DOB (MM/DD) ____/____/____ Gender ☐ M ☐ F Primary Language ☐ English ☐ Spanish

Race

☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian/White
☐ Hispanic/Latino ☐ Pacific Islander ☐ Other _____

Date of Cancer Diagnosis (Month/Year) ____/____ Type of Cancer (primary site) _____

Insurance (check all that apply) ☐ Private ☐ Medicare ☐ Medicaid/TennCare ☐ Military Program ☐ Uninsured ☐ Declined

SELECT ONE

☐ INFORMATION PACKET ONLY: Free information is sent within 1-2 business days of ACS receiving this form.

OR

☐ INFORMATION PACKET & RESOURCES: Patient wants free information AND a call within 2 business days to discuss resources selected. Please note details in comments area.

Select resources needed for the patient/caregiver:

- ☐ Lodging
- ☐ Look Good ... Feel Better (female cancer patients only)
- ☐ Reach to Recovery (breast cancer patients only)
- ☐ Other resources _____
- ☐ Transportation

COMMENTS

Send information packet by ☐ Mail OR ☐ Email (reconfirm) _____

Instead of patient, contact the following if resources are requested: ☐ Family Member ☐ Caregiver ☐ Health Professional

Name _____ Email _____

Primary Phone (____) _____ OK to leave message? ☐ Yes ☐ No

Kentucky Women's Cancer Screening Program 1-2GDG/KC

Referring Clinician's Name (print) _____ Primary Ph # (____) _____

Department _____ Clinician's Email _____

☐ PATIENT'S CONSENT (HIPAA): Patient understands the HIPAA privacy policy and agrees with the disclosure of this information to the American Cancer Society for the purposes of applicable follow up. The American Cancer Society is a private organization and does not share personal health information.

PATIENT'S SIGNATURE _____

Email to: midsouth.cancerinfo@cancer.org OR FAX form to: 1-866-265-0564



Section 1 of Referral form– Basic Information



Patient Referral Form

Please print clearly for prompt service.

For immediate assistance call us anytime at 1-800-ACS-2345.



Patient's Name _____		Email _____	
Address/City/State/Zip _____			
Primary Ph # (_____) _____		<input type="checkbox"/> Hm <input type="checkbox"/> Wk <input type="checkbox"/> Cell	Alternate Ph # (_____) _____
Best time to call _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		OK to leave message identifying ourselves as ACS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DOB (M/D/Y) ____/____/____		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> African American/Black	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian/White
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Other _____	
Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish			
Date of Diagnosis (Month/Year) ____/____		Type of Cancer (site) _____	
Insurance (check all that apply) <input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Military Program <input type="checkbox"/> Uninsured <input type="checkbox"/> Declined			



Referral form section 2— Level of follow-up



SELECT ONE LEVEL OF FOLLOW UP

☐ **INFORMATION ONLY:** Patient receive information packet

☐ **SERVICES NEEDED:** Patient wants free information but ALSO should receive follow up call within 2 business days for assessment of resources and programs as indicated. Provide any needed details in the COMMENTS box.

- ☐ Lodging
- ☐ Look Good Feel Better
- ☐ Reach to Recovery
- ☐ Other resources
- ☐ Transportation

Referral section 3— Patient consent



☐ **PATIENT'S CONSENT (HIPAA):** Patient understands the HIPAA policy and agrees with the disclosure of this information to the American Cancer Society for the purposes of applicable follow up. The American Cancer Society is a private organization and does not share personal health information.

PATIENT'S SIGNATURE (if applicable) _____

Referral form section 4— Facility Contact Information



Kentucky Women's Cancer Screening Program

1-2GDGJKC

Referring Clinician's Name (print) _____ Primary Ph # (____) _____

Department _____ Clinician's Email _____

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PATIENT'S SIGNATURE _____

Email to: midsouth.cancerinfo@cancer.org

OR

FAX form to: 1-866-265-0564





**THANK YOU FOR TEAMING UP
WITH US TO HELP YOUR
PATIENTS QUALITY OF LIFE.**

